IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
FITZGERALD, P.J. AND HOEKSTRA AND MARKEY, JJ.

EILEEN HALLORAN, Temporary Personal Representative of the **ESTATE OF DENNIS J. HALLORAN, Deceased,**

Plaintiff-Appellee,

v

RAAKESH C. BHAN, M.D. and **CRITICAL CARE PULMONARY MEDICINE, P.C.,**

Defendants-Appellants

and

BATTLE CREEK HEALTH SYSTEMS,

Defendant.

Supreme Court No. 121523

Court of Appeals No. 224548

Calhoun County Circuit Court No. 98-3953-NH

APPELLEE'S BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

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STATEMENT CONCERNING JURISDICTIONAL SUMMARY

The Jurisdictional Summary found at page 13 of Appellants' Brief on Appeal and at page x of the Brief on Appeal of Defendant Battle Creek Health Systems taken and read together, are complete and correct.

STATEMENT CONCERNING STANDARD OF REVIEW

The Statement Concerning Standard of Review found at page 13 of Appellants' Brief on Appeal and at page 7 of the Brief on Appeal of Defendant Battle Creek Health Systems taken and read together, are complete and correct.

COUNTER-STATEMENT OF QUESTIONS INVOLVED NOT REQUIRED

Though the Appellants and Defendant Battle Creek Health Systems each state the questions in a slightly different manner, they are both fairly stated according to this Court's March 25, 2003 Order granting leave to appeal. Therefore, they are accepted as the matrix for the argument of this case.

COUNTER-STATEMENT OF FACTS

The Statement of Facts of Appellants and of Defendant Battle Creek Health Systems are both accurate, but each lacks some facts important to this Court's consideration of and decision in this case.

Those facts necessary to complete the factual context of this case are as follows:

1. Paragraph 6 of Plaintiff-Appellee's Complaint alleges the following:

> "6. That Defendant Raakesh C. Bhan is and was at all times relevant hereto a medical doctor licensed to practice medicine by the State of Michigan and in his care of Plaintiff's decedent, was practicing critical care medicine in which he is and was at all times relevant hereto board certified." (Emphasis supplied.) (Appellants' Appendix p. 14a.)

Appellant Dr. Bhan and his professional corporation answered paragraph 6 as follows:

> "6. As to the allegations contained in paragraph 6 of Plaintiff's Complaint, these Defendants admit same." (Appellee's Appendix p. 2b.)

Defendant Battle Creek Health Systems answers paragraph 6 as follows:

> "6. The allegations in paragraph 6 are admitted based upon information and belief." (Appellee's Appendix p. 8b.)

2. The affidavit of T. James Gallagher, M.D. attached to Plaintiff-Appellee's Complaint as Exhibit C says in paragraphs 1 and 2 that he is licensed to practice medicine in the State of Florida and practices the specialty of critical care medicine and is familiar with the standard of care of critical care medicine. (Appellants' Appendix pp. 25a-26a.)

3. Dr. Gallagher's CV was furnished to Defendants as an exhibit attached to answers to interrogatories mailed to Defendants on January 25, 1999. (Appellee's Appendix p. 14b.)

4. Appellant Dr. Bhan's CV attached as Exhibit A to his motion to strike Dr. Gallagher as an expert witness says near the bottom of the first page that he is board certified in critical care as of November, 1989. The date of our incident is September 30-October 1, 1994 and on the third page, the fourth entry under Membership & Activities in Professional Society shows that since 1986, Dr. Bhan has been a member of the American Society of Critical Care Medicine. (Appellants' Appendix pp. 36a-42a.)

5. Both Defendant-Appellant Dr. Bhan and expert witness Dr. Gallagher are members of the professional society, The American Society of Critical Care Medicine. That society has its own journal, Critical Care Medicine, attached as Exhibit 3 to Plaintiff-Appellee's brief in the trial court. It is a photocopy of two pages from a recent edition of that journal which shows its editorial board includes expert witness Dr. Gallagher. (Appellee's Appendix pp. 75b-76b.)

6. Further, the Court should look at the medical record – emergency department report – in this case. It is attached as Exhibit 4 to Plaintiff-Appellee's brief in the trial court. It states the following: "Dr. Bhan, Intensive Care Specialist, was contacted, came, saw the patient and admitted him to the hospital." (Appellee's Appendix p. 77b.)

7. The Society of Critical Care Medicine has produced a definition of an intensivist which clearly demonstrates that it is a specialty area of practice. A photocopy of those guidelines was attached to Plaintiff-Appellee's brief in the trial court as Exhibit 5. (Appellee's Appendix pp. 78b, 79b, 80b, 81b, 82b, 83b, 84b.)

8. Expert witness Dr. Gallagher's specialty is critical care.

> "Q. What is your area of specialty, doctor?
>
> A. Critical care." (Gallagher depo, p. 6, lines 3-4; Appellee's Appendix p. 86b.)

9. Expert witness Dr. Gallagher's certification in critical care is essentially the same as Dr. Bhan's.

> "Q. Are you considered board-certified in critical care or is yours a certificate of special qualification?
>
> A. There is no board certification in critical care or in any specialties. They're all a certificate of special qualification or special competence.
>
> Q. Is that the same certification that Dr. Bhan has if you know?
>
> A. Yes, essentially." (Gallagher depo, p. 7, lines 2-9; Appellee's Appendix p. 87b.)

10. Expert witness Dr. Gallagher at the time of the occurrence in case devoted about 75-80% of his time to clinical practice and 90-95% of that was critical care.

> "A. About – '94, let me think for a second. About 75 to 80 percent of my time was clinical, and about 90 percent of that to 95 percent during that time was critical care. The other remaining non clinical time was varied between administrative responsibilities and research." (Gallagher depo, p. 9, lines 11-15; Appellee's Appendix p. 89b.)

11. Expert witness Dr. Gallagher judges this case as a critical care physician.

> "A. . . . I judge this case on the basis of a critical care physician judging another critical care physician taking care of an acutely ill patient." (Gallagher depo, p. 8, lines 23-25; Appellee's Appendix p. 88b.)

12. Expert witness Dr. Gallagher treats people suffering from alcoholism.

> "Q. Do you treat people suffering from alcoholism?
>
> A. Yes." (Gallagher depo, p. 22, line 25 – p. 23, line 1; Appellee's Appendix pp. 94b, 95b.)

13. Expert witness Dr. Gallagher testified there are numerous violations of the standard of care in Defendant-Appellant Bhan's treatment of Mr. Halloran.

> "Q. Why don't you tell me in whatever is most organized for you what your opinions in this case are?
>
> A. Okay. Mr. Halloran was a patient with known liver disease and a known alcoholic who came into the hospital on 9/30/94 complaining of diffuse abdominal pains, and the initial work up at that time indicated that he did have ascites and that he had a number of blood tests done and the findings included the fact that he had a degree of renal insufficiency as indicated by a BUN of 40, creatinine of 4.7; that he had a low white blood cell count of 2.9, and a platelet count of 70,000, and a bandsdemia of 49 percent indicative of sepsis. He had a blood gas which indicated a compensated metabolic acidosis, PCO2 of 20, pH of 7.34, bicarbonate of 11. He was tachypnic reading more than twice the normal rate at about 32 per minute. He was tachycardic at 120 per minute.
>
> The laboratory data would suggest that sepsis was a primary consideration in a patient who had been compensated up until then, and that the metabolic acidosis was indicative, perhaps renal insufficiency as well as poor peripheral perfusion.

He was admitted – Let me back up a minute. He was then admitted to the hospital and placed on a regular hospital ward where vital signs are to be done twice a day. In a patient who already demonstrated vital signs –

MR. CURI: I object. I didn't understand what you said about vital signs, they were to be taken twice a day did you say?

BY THE WITNESS:

A. Where the policy is my understanding on the floor vital signs were to be done twice a day.

MR. CURI: I object to the foundation of that.

BY THE WITNESS:

A. That's in one of the depositions by one of the nurses. Okay. Go on?

BY MR. BEAN:

Q. Go ahead.

A. Let me get back to where I was here.

Okay. Failure to work the patient up for sepsis including culturing the patient and placing him on antibiotics until at least the cultures came back, that's below the standard of care.

Failure to determine the cause of the metabolic acidosis, to treat the metabolic acidosis was below the standard of care.

Failure to place the patient in the intensive care unit – Did I say this already? -- was below the standard of care given the instability demonstrated by the high respiratory rate, the hypothermia which I neglected to mention, a temperature of 96 degrees and the tachycardia.

There is no documentation of the extent of his liver disease except an SGOT that turns out was 126 similar to what it had been about a year and a half previous and the PT of 15 seconds.

The patient was started on Demerol which was increased in frequency from initially every four to six hours to every three hours. This is a drug when given to a patient who is in respiratory acidosis is going to have an altered response in terms of breathing to this narcotic which was not taken into account clearly by the physicians. By Dr. Bhan in this case.

As a result, after the fourth dose of Demerol, the last one being at 01:00 on 10/1/94, and having been diaphoretic and tachypnic the entire time he was on the hospital floor as documented by the nursing notes, Dr. Bhan saw the patient and reported that he had a respiratory rate of six to eight per minute which was clearly indicative of a narcotic induced respiratory depression in this case secondary to Demerol. This was not treated with Narcan which is a reversal agent for that and that was below the standard of care. The patient was not intubated at that time as another method of treatment for the respiratory depression. That was below the standard of care.

Let me go to one page here before I go on. The patient then developed a cardiac arrest that appears to

have begun at either 01:43 or 01:50. I think it's 01:43 and a half is the way it's written here. However, the patient wasn't intubated until 2:03 as indicated on the cardiac arrest sheet which would be below the standard of care.

The patient never had his metabolic acidosis treated or corrected prior to the arrest. That was below the standard care. And during the arrest again bicarbonate was not given in a patient already known to have an underlying metabolic acidosis, and that was below the standard of care.

All of these factors together in this patient contributed to his death and all were preventable." (Gallagher depo, p. 18, line 14 – p. 21, line 25; Appellee's Appendix pp. 90b, 91b, 92b, 93b.)

SUMMARY OF ARGUMENT

Critical care medicine is a specialty recognized by all of the parties in this case and by the medical profession. The doctor and hospital in this case have admitted that.

Both Defendant-Appellant Dr. Bhan and expert witness Dr. Gallagher were practicing the specialty of critical care medicine at the time of the occurrence that is the basis of this action.

Defendant-Appellant Dr. Bhan is not a general practitioner; holds himself out as a specialist in critical care medicine, and has advanced training and expertise in critical care medicine.

The statute involved in this case is properly construed by addressing all of the language in it and that means that the word "specialist" and the phrase "that specialty" refer to the specialty being practiced by Defendant-Appellant Dr. Bhan in treating Plaintiff-Appellee's decedent, Mr. Halloran.

If a certificate of added qualification is a board certification, then both Defendant-Appellant Dr. Bhan and expert witness Dr. Gallagher are board certified in that specialty.

If a certificate of added qualification is not a board certification, then there is no board certification for critical care medicine and board certification is not relevant.

ARGUMENT

ISSUE I: A STANDARD OF CARE EXPERT WITNESS MAY BE QUALIFIED UNDER MCL 600.2169(1)(a) TO PRESENT EXPERT TESTIMONY AGAINST A DEFENDANT PHYSICIAN WHERE THE PROFFERED WITNESS DOES NOT POSSESS THE SAME BOARD CERTIFICATION AS THE DEFENDANT PHYSICIAN.

A. MCL 600.2169(1)(a) is the statute involved

The statute provides as follows:

"(1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty."

B. The rules of statutory construction applicable are basic, long-standing, and straightforward

This Court has developed and applied several basic, long-standing and straightforward rules of statutory construction over the years. Those rules have been stated as follows:

1. Provisions of statutes should be construed with common sense and in a manner designed to give each provision its full effect. Reed v Secretary of State, 327 Mich 108, 113; 41 NW2d 491 (1950); Jones v Grand Ledge Public Schools, 349 Mich 1, 9-10; 84 NW2d 327 (1957).

2. Courts are directed to construe and apply entire statutes, rather than review fragments of statutes and attempt to give independent meaning to fragments as opposed to the statutory scheme as a whole. Reed, supra, at 113.

3. Courts are precluded from interpretation of the statute which would destroy the plain meaning of an otherwise unambiguous statute. Attorney General v Bruce, 422 Mich 157, 165; 369 NW2d 826 (1985); Jones, supra, at 9-10.

The Court of Appeals in this case (Appellants' Appendix p. 88a) cited additional relevant rules which are similarly set forth in Tate v Detroit Receiving Hospital, 249 Mich App 212, 217; 642 NW2d 346 (2002):

4. The primary goal in construing a statute is to determine and give effect to the intent of the Legislature. Frankenmuth Mutual Ins Co v Marlette Homes, Inc, 456 Mich 511, 515; 573 NW2d 611 (1998).

5. The specific language of the statute is the first source for determining the Legislature's intent, In re MCI Telecommunications Complaint, 460 Mich 396, 411; 596 NW2d 164 (1999).

6. When the plain and ordinary meaning of the language is clear, judicial construction is normally not needed or permitted, Sun Valley Foods Co v Ward, 460 Mich 230, 236; 596 NW2d 119 (1999).

7. Courts can look beyond the statutory language only if it is ambiguous. Nawrocki v Macomb Co Rd Comm'n, 463 Mich 143, 159; 615 NW2d 702 (2000).

8. In such cases, courts must seek to give effect to the Legislature's intent through a reasonable construction. Macomb Co Prosecutor v Murphy, 464 Mich 149, 158; 627 NW2d 247 (2001).

C. The questions of "specialty" and expert witness qualifications are addressed to the context of the occurrence and the time of the occurrence

The statute directs us to ". . . the time of the occurrence that is the basis for the action . . ."

It tells us that the standard of care expert must be practicing the same specialty as the defendant at the time of the occurrence. That is the plain and obvious meaning of the statute. To see and understand that does not require resorting to any sophisticated definitions or rules of construction. It is right there in the statute.

D. The specialty involved in this case is critical care medicine

Each of the defendants, both Defendant-Appellant Dr. Bhan and Defendant Battle Creek Health Systems, admitted in their answers to paragraph 6 of the Complaint that Defendant-Appellant Dr. Bhan was practicing critical care medicine in his care of Plaintiff-Appellee's decedent.

That certainly shows that the medical community—both doctors and hospitals—consider critical care medicine to be a specialty.

Further, both the Defendant-Appellant Dr. Bhan and the expert witness Dr. Gallagher are members of the Society of Critical Care Medicine. That society provides "Guidelines for the Definition of an Intensivist and the Practice of Critical Care Medicine".

> "**I. Guidelines for the Definition of an Intensivist**
>
> **An Intensivist:**
>
> A. Is trained and certified through a primary specialty. Has successfully completed an Accreditation Council for Graduate Medical Education approved training program in critical care medicine and/or has a certificate of special qualification in critical care or, through January 1995, has equivalent qualifications.
>
> B. Promotes quality care in the ICU and efficient use of critical care resources.
>
> C. Devotes greater than 50% of professional time to the practice of critical care medicine.
>
> D. Willingly participates in a unit-based, hospital-approved coverage system that provides 24 hr/day, 7 day/wk coverage by physicians who possess similar credentials in critical care.
>
> E. Is able to perform the usual critical care procedures, including, but not limited to:
>
> 1. Maintenance of the airway to include tracheal intubation and mechanical ventilation.

2. Arterial puncture for collection of arterial blood samples.

3. Placement of intravascular catheters and monitoring devices including:

   a. Arterial catheters
   b. Peripheral venous catheters
   c. Central venous catheters
   d. Pulmonary artery catheters.

4. Placement of temporary transvenous pacing wire (optional for pediatric intensivists)

5. Cardiopulmonary resuscitation

6. Tube thoracostomy"

. . .

"F. The role of the intensivist has two major components:

1. Patient Care:

The intensivist should be able to serve as the team leader providing managed care within the ICU, integrating and titrating the care of the patient with complex illness or injury including multi-system failure. The intensivist may provide these services as the patient's attending physician or as a physician providing concurrent care in collaboration with the patient's attending physician. Is able to manage patients with commonly encountered critical care conditions including, but not limited to:

a. Hemodynamic instability

b. Respiratory insufficiency or failure, with or without a need for mechanical ventilatory support

c. Acute neurological insult including treatment of intracranial hypertension

d. Acute renal failure or insufficiency

e. Acute life threatening endocrine and/or metabolic derangements

f. Drug overdoses, drug reactions, and poisonings

g. Coagulation disorders

h. Serious infections

i. Nutritional failure requiring nutritional support." (Appellee's Appendix pp. 80b-81b.)

These guidelines show that the focus of care of an intensivist or of an intensive care specialist is critical care and that the care expected and provided is not dependent on any "primary" board certification of the intensivist or critical care specialist.

That actually makes sense if one looks at Defendant Battle Creek Health Systems' Brief, Exhibit D. The sub-specialty of critical care for anesthesiology, internal medicine, obstetrics and gynecology, and

neurological surgery were all approved by the American Board of Medical Specialists in 1985. That evidences the coordination among the so-called "primary" boards to provide a consistent level of standard of care for the critical care specialists. It only makes sense that what an internal medicine doctor would have to learn to become a critical care specialist would differ from what an anesthesiologist would have to learn. Each is going to have to learn some of what the other already knows. Therefore, each primary board would test differently and the education would be different to certify a physician as a critical care specialist.

E. The emergency room physician called for "Dr. Bhan, Intensive Care Specialist"

The Emergency Department Report of Defendant Battle Creek Health Systems (Appellee's Appendix p. 77b) shows at its end that an "Intensive Care Specialist" not an Internal Medicine Specialist was called.

F. The plain words of the statute are ". . . board certified in that specialty." They are not ". . . certified by the same board."

The relevant section of the statute ends with the phrase which requires the expert witness to be "board certified in that specialty." It is plain that the words tell us the specialty is what is critical not the board. If the intent

had been to require certification by the same board, the legislature could have said that. It did not. The language is not ambiguous. It is clear.

This is why one who does not possess "the same board certification as the defendant physician" may give expert testimony as to the standard of care issues. The statute plainly and clearly says so.

G. Defendant-Appellant Dr. Bhan holds himself out as being board certified in Critical Care Medicine

In his curriculum vitae (Appellants' Appendix p. 36a), Defendant-Appellant Dr. Bhan tells the world he is board certified in critical care. That certainly is persuasive evidence as to what he considers a specialty. It is also consistent with what the medical community considers a specialty. The emergency physician called for Defendant-Appellant Dr. Bhan as an "Intensive Care Specialist". The primary boards granting certificate of added qualification in critical care medicine recognize it as a specialty. The Society of Critical Care Medicine also recognizes it and defines it. It is really undisputed that critical care is a specialty. The question is whether one may be board certified in it. It may be that technically it is not possible because the boards recognize it by giving certificates of added qualifications. Defendant-Appellant Dr. Bhan considers that a board certification. That is a window into what the medical community thinks.

H. It makes no difference whether a certificate of added qualification is a board certification because the specialty is the thing.

Since critical care is a specialty recognized by the medical community, the result in this particular case should not depend on whether a certificate of added qualification is a board certification. That is because if it is, both Defendant-Appellant Dr. Bhan and expert witness Dr. Gallagher are certified in that specialty. If it is not, then there is no board certification for that specialty. The Court of Appeals in this case and in Tate, supra, both gave meaning to the portion of MCL 600.2169(1)(a) which says ". . . specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered."

Further discussion of the meaning of the word "specialty" and the phrase "that specialty" leads to the next two issues the Court has asked counsel to address.

ISSUE II: THE PROPER CONSTRUCTION OF THE WORD "SPECIALTY" IN THE FIRST SENTENCE OF MCL 600.2169(1)(a) IS THAT A SPECIALIST IS ONE WHO IS NOT A GENERAL PRACTITIONER; ONE WHO HOLDS HIMSELF OR HERSELF OUT AS A SPECIALIST; AND ONE WHO HAS ADVANCED TRAINING AND EXPERTISE IN A PARTICULAR FIELD OF GENERAL MEDICINE.

A. A specialist is one who is not a general practitioner.

The Civil Jury Instructions in Michigan dealt with the issue of medical specialty for many years. The current incarnation of the relevant instructions is M Civ JI 30.01 which reads as follows:

> "
> When I use the words 'professional negligence' or 'malpractice' with respect to the defendant's conduct, I mean the failure to do something which a <Name profession.> of ordinary learning, judgment or skill in [this community or a similar one / <Name particular specialty.>] would do, or the doing of something which a <Name profession.> of ordinary learning, judgment or skill would not do, under the same or similar circumstances you find to exist in this case.
>
> It is for you to decide, based upon the evidence, what the ordinary <Name profession.> of ordinary learning, judgment or skill would do or would not do under the same or similar circumstances."

What that instruction suggests is that a second part of the definition of a specialist when it refers to a doctor is that a specialist is one who is not a general practitioner.

B. This Court has held that a doctor who holds himself or herself out as a specialist is a specialist.

In Naccarato v Grob, 384 Mich 248; 180 NW2d 788 (1970), this Court described a specialist in a medical malpractice case context as follows:

> In reaching our decision today, we rely on the reasoning in Wood v. Vroman (1921), 215 Mich. 449, 184 N.W. 520: (Where the defendant holds himself out as a specialist he is) "obligated to bring to the discharge of his duty that degree of skill and knowledge possessed by physicians who are specialists in the Light of present day scientific knowledge." (Wood v Vroman, Supra, 465—466, 184 N.W. 525). (Emphasis added). Naccarato, supra, at 253.

Here, that clearly includes Defendant-Appellant Dr. Bhan who, by his admission and by his curriculum vitae, holds himself out as a specialist in critical care medicine.

However, the test of Naccarato and Wood is a very general one and more definition is desirable.

C. The Michigan Court of Appeals has held that a doctor is a specialist on the basis of advanced training and expertise.

The only Michigan case counsel for Plaintiff-Appellee have been able to find which construes the word "specialist" in the context of a medical malpractice case and the standard of care is one which addresses it in the context of the predecessor of SJI2d 30.01, the predecessor of M Civ JI 30.01, and the predecessor language of MCL 600.2912(a). That is the case of Jalaba v Borovoy, 206 Mich App 17; 520 NW2d 349 (1994), lv den 448 Mich 900; 533 NW2d 312 (1995). There, the Court of Appeals, at page 22, defined a doctor specialist as follows: "A doctor or physician is a specialist on the basis of advanced training and expertise in a particular field of general medicine."

In this case before this Court, all parties recognize critical care as a specialty and it certainly satisfies the guidelines of the Civil Jury Instructions, the Michigan Supreme Court, and the Michigan Court of Appeals. Defendant-Appellant Dr. Bhan is not a general practitioner. He holds himself out as a specialist. He has advanced training and expertise in the particular field of critical care.

ISSUE III: THE PROPER CONSTRUCTION OF THE PHRASE "THAT SPECIALTY" IN THE SECOND SENTENCE OF MCL 600.2169(1)(a) IS THAT IT IS THE SPECIALTY BEING PRACTICED BY THE DEFENDANT DOCTOR IN TREATING THE PLAINTIFF PATIENT.

A. The word "However" introducing the second sentence adds a requirement or qualification to the first sentence.

Plain, ordinary meaning and reading of a sentence beginning with the word "However" is that it adds to, extends and modifies that which comes before it. There really is no disagreement about that in this case. What comes before the "However" sentence containing the phrase "that specialty" is the sentence discussed in the context of Issues I and II.

That first sentence deals with a specialist and requires the expert testifying against the specialist to specialize at the time of the occurrence in the same specialty. It is that context in which testimony is offered for or against the defendant. The court in Tate, supra, had it exactly right when it held as follows:

> "Subsection 2169(1)(a) specifically states that an expert witness must 'specialize[ ] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The statute further discusses board-certified specialists and requires that experts testifying against or on behalf of such specialists also be "board certified in that specialty." The use of the phrase "at the time of the occurrence that is the basis for the action" clearly indicates that an expert's specialty

> is limited to the actual malpractice. Moreover, the statute expressly uses the word "specialty," as opposed to "specialties," thereby implying that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold." Tate, supra, at 218.

B. The added requirement has to do with "board certification"

The first sentence under consideration talks about the situation where "if . . . (the defendant doctor) . . . is a specialist," and the second sentence begins with that same language but adds ". . . who is board certified" to the language. Since the second sentence clearly refers back to the specialist described in the first sentence, it makes no sense to say that the board certification mentioned in the second sentence refers to anything other than the specialty involved in the treatment of the plaintiff patient.

C. "That specialty" refers to the specialty involved in treatment of plaintiff patient

Application of the logic of parts A and B of the argument on this Issue III requires the Court to find "that specialty" refers to the specialty involved in the treatment of the plaintiff patient. There simply is no other board certification referred to and no other specialty referred to in the statute under consideration.

D. Any other construction would lead to absurd results

Consider the absurd result if the phrase "that specialty" in the second sentence were held to refer to any or all board certifications held by a defendant doctor. Start with the premise that any doctor board certified in a specialty may practice in another specialty without board certification or special license. That means that a dermatologist may legally practice neurosurgery. The absurd result of a different construction of the statute would be that only a dermatologist could testify against the dermatologist practicing neurosurgery who negligently injures a patient. It makes absolutely no sense to require the standard of care expert in such a situation to be a dermatologist rather than a neurosurgeon. That is because the dermatologist is practicing the specialty of neurosurgery in treating the hypothetical patient injured by that board certified dermatologist practicing neurosurgery. The situation is the same if the defendant doctor has more than one board certifications as was the case in Tate, supra. Suppose the board certified dermatologist practicing neurosurgery was also board certified in psychiatry. Dermatology and psychiatry are not involved in the neurosurgery which results in the negligent injuries of the hypothetical patient. Again, it would make absolutely no sense to require that the standard

of care expert in such a situation be a dermatologist and a psychiatrist and a neurosurgeon.

What is involved in this case before the Court is critical care medicine. That is the specialty.

RELIEF

WHEREFORE, Plaintiff-Appellee, Eileen Halloran, Temporary Personal Representative of the Estate of Dennis J. Halloran, Deceased, respectfully requests that this Honorable Court affirm the decision of the Michigan Court of Appeals.

Dated: June 19, 2003.

Respectfully yours,

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